A Again, I don't know when I weaned myself off the brace.

Q Okay.

A I just know I went for the follow-up visits as required.

Q Okay, after the brace was removed, or you stopped using the brace, put it that way, did you have any follow-up treatment for your back?

A I don't recall.

Q Did you have any physical therapy?

A Yes.

Q And do you recall how many physical therapy visits you made?

A I don't recall.

Q Do you think you had more than six?

A I don't recall.

Q More than twelve?

A I don't recall.

Q I have 10/14/02 as the last medical date of service at UNC Hospital. Do you remember going back to the hospital October 14 of 2002?

A I know I went as I was required to go, so whatever those dates are, they are.

Q Okay, I do not have any records after August 12, 2002, which was for outpatient rehabilitation.

Have you had any treatment for your back other than the October 14, 2002 possible visit at UNC Hospital since that time?

A Not that I recall.

Q Never seen a doctor for your back in the last two years?

A No.

Q Do you still have back problems?

A Yes.

Q What type of back problems do you have?

A Occasional pain.

Q What do you do for the occasional pain, treatment?

A I suffer.

Q Do you take any medication?

A I take no medication.

Q Why don't you take medication?

A I don't want to be on any type of medication or drug.

Q Do you take aspirin?

A Yes.

Q Do you take Advil?

A No.

Q When you get your back pain, does it ever prevent you from working?

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF NORTH CAROLINA
SOUTHERN DIVISION
In Admiralty
CIVIL ACTION NO. 7:05-CV-48-F(3)

Stephen Norman Ostrov and Mara Ann Ostrov, Plaintiffs v. Walter W. Winner, II and Chad A. Winner, in personam, and the S.S. Winner Queen, Official Number 546782, her engines, Furniture, tackle and apparel, in rem, Defendants	**Plaintiff's Supplemental Rule 26(a)(3) Disclosures**

Plaintiffs, Stephen Norman Ostrov and Mara Ann Ostrov by counsel, make the following Supplemental Pretrial Disclosures under Rule 26(a)(3) of the Federal Rules of Civil Procedure:

(A) WITNESSES

Names and addresses of witnesses whose testimony the Plaintiffs will or may present are set forth below. Plaintiff reserve the right to call any witnesses identified by Defendants and to call witnesses not previously listed for rebuttal or impeachment without prior disclosure.

Plaintiff expects to present the following witnesses at trial:

1. Orthopaedic Center of South Florida, P.A.
Audie M. Rolnick, MD
600 South Pine Island Road
Suite 300
Plantation, Florida 33324

(B) WITNESSES WHOSE TESTIMONY MAY BE PRESENTED BY MEANS OF A DEPOSITION

The above referred to medical providers

(C) EXHIBITS

Plaintiff reserves the right to utilize any exhibits listed by Defendants and further reserves the right to use, introduce, or rely upon any other discovery materials, including but not limited to

deposition transcripts, for impeachment or rebuttal or on cross-examination, or in the event a witness who was deposed or subpoenaed to trial, fails to appear.

Depending on what portions, if any, of the exhibits which the Court permits Defendants to introduce, Plaintiff reserves the right to introduce any other parts pursuant to Fed.R.Civ.P. 32(a)(4). Plaintiff reserves the right to use, introduce, or rely upon any other discovery materials, including but not limited to deposition transcripts, for impeachment or rebuttal or on cross-examination.

In addition to the foregoing, Plaintiff may use the following exhibits at trial:

k. Office records, billing statements and prognosis form from treating physician stated above, which were received in plaintiff's attorney's office on August 8, 2006.

This the 14th day of August, 2006.

THE LAW OFFICES OF RICHARD S. HUNTER, JR.

BY: _____

Richard S. Hunter, Jr.
Attorney for Plaintiff
NC Bar No. 9276
133 Fayetteville Street Mall, Suite 300
Post Office Drawer 470
Raleigh, NC 27602-0470
Telephone: (919) 831-8722
Facsimile: (919) 831-8734
Email: hunteratty@aol.com

CERTIFICATE OF SERVICE

This is to certify that the undersigned has this date served this Plaintiff's Rule 26(a)(3) Disclosures upon all other parties to this cause by facsimile and by depositing a copy thereof, postage paid in the United States mail, Raleigh, North Carolina, addressed to:

Andrew Hanley
Crossley, McIntosh, Prior & Collier, P.A.
2451 South College Road
Wilmington, NC 28412
Facsimile: 910/251-0446

This the 14th day of August, 2006.

THE LAW OFFICES OF RICHARD S. HUNTER, JR.

BY: _____

Richard S. Hunter, Jr.
Attorney for Plaintiff
NC Bar No. 9276
133 Fayetteville Street Mall, Suite 300
Post Office Drawer 470
Raleigh, NC 27602-0470
Telephone: (919) 831-8722
Facsimile: (919) 831-8734
Email: hunteratty@aol.com

ORTHOPAEDIC CENTER OF SOUTH FLORIDA, P.A.
600 SOUTH PINE ISLAND ROAD, SUITE 300
PLANTATION, FLORIDA 33324

MA 1 6/29

PatientID: 261446
Patient Name: STEPHEN OSTROV
Date of Birth: 09/22/1959
Date of Service: 06/28/2006
Physician Seen: AUDIE M ROLNICK MD

Tamara ASAP NPI posted

INITIAL OFFICE EVALUATION

The patient is a 46-year-old male who comes in today complaining of pain in the mid back area. There is stiffness in the mid back area. The patient had a boating accident that occurred in April of 2002. After this accident he was diagnosed with a burst fracture of the L3 vertebra. He was treated with a hyperextension brace. This occurred in North Carolina. Eventually, it did improve. After a few months of physical therapy, he was discharged from that physician's care. Now he has not had treatment in this period of time. However, he still gets stiffness and pain. He is concerned about that and would like to have it evaluated. He has no other complaints today. His job requires him to do a fair amount of standing. He has aching in the mid part of the back depending on his activity level. He is limited to some degree with what he can do. He has no radiation, numbness or paresthesias. The patient has no GU/GI complaints.

MEDICAL HISTORY

The patient's comprehensive past medical history form has been reviewed with the patient and noted on the chart. He is medically healthy.

PHYSICAL EXAMINATION

I have examined the patient. The patient is a well-developed male with no acute distress. The examination of the lumbar spine shows mild mid lumbar tenderness. His flexion is limited to 65 degrees. He is able to
toe-and-heel walk. The straight leg raise is negative. Hips have equal range of motion. Sensory, motor and reflexes are intact.

IMAGING STUDIES

X-rays of the lumbar spine show a burst fracture involving the L3 vertebra. There is some posterior protrusion of the vertebra. However, it is difficult to tell how far into the spinal canal this goes without a CT scan or further testing, including an MRI scan. There is degenerative changes to the L2-3 vertebral disc space as well.

IMPRESSION

Status post burst fracture of the L3 vertebra with some degenerative changes of the disc space at the L2-3 level, mild posterior protrusion of the posterior body fragments of the L3 vertebra into the canal, no neurologic deficits

RECOMMENDATIONS

ORTHOPAEDIC CENTER OF SOUTH FLORIDA, P.A.
600 SOUTH PINE ISLAND ROAD, SUITE 300
PLANTATION, FLORIDA 33324

PatientID: 261446
Patient Name: STEPHEN OSTROV
Date of Birth: 09/22/1959
Date of Service: 06/28/2006
Physician Seen: AUDIE M ROLNICK MD

At this point in time, the patient is recommended to use the heating pads and stretching and exercise program. Right at this point the pain is not bad enough to pursue this any further. Should the pain get worse, the patient may require an MRI scan or CT scan to evaluate this vertebral level. One can expect that he may develop increasing stiffness and perhaps aching in the future relating to this vertebral level. I will have to reevaluate him as necessary. Follow up p.r.n.

AMR/sab

PLEASE PRINT

AME: STEPHEN OSTROM DATE: 6/28/06 SS# 119-54-9309 AGE: 45

HY ARE YOU SEEING THE DOCTOR TODAY? DR ROLNICK

HO IS YOUR MEDICAL DOCTOR ?

HAT IS YOUR OCCUPATION? SALES

HAT MEDICATIONS DO YOU TAKE DAILY? (DRUG NAME ONLY) N/A

O YOU HAVE ANY ALLERGIES? (SPECIFICALLY TO MEDICATIONS OR DYES) N/A

RE YOU RIGHT HANDED (✓) OR LEFT HANDED ( )?

AN YOU TAKE ASPIRIN? YES (✓) NO ( )

OULD YOU POSSIBLY BE PREGNANT? YES ( ) NO (✓)

HAVE YOU EVER BEEN TESTED FOR OSTEOPOROSIS? YES ( ) NO (✓) IF YES, WHEN?

DO YOU NOW OR HAVE YOU IN THE PAST HAD ANY OF THE FOLLOWING:

HEART DISEASE	YES ( ) NO (✓)	URINARY	YES ( ) NO (✓)
HIGH BLOOD PRESSURE	YES ( ) NO (✓)	THYROID	YES ( ) NO (✓)
BLEEDING PROBLEMS	YES ( ) NO (✓)	LUNG	YES ( ) NO (✓)
EPILEPSY	YES ( ) NO (✓)	CANCER	YES ( ) NO (✓)
DIABETES	YES ( ) NO (✓)	ARTHRITIS	YES ( ) NO (✓)
STOMACH/ULCER	YES ( ) NO (✓)		

HAVE YOU HAD SURGERY IN THE PAST? YES ( ) NO (✓) IF YES, LIST TYPE AND DATE OF SURGERY:

ANY ANESTHETIC COMPLICATIONS?

HAVE YOU BEEN HOSPITALIZED FOR A PROBLEM OTHER THAN LISTED ABOVE? YES (✓) NO ( )

IF YES, FOR WHAT CONDITION? FRACTURE L2 VERTEBRA

FAMILY HISTORY

Member	Alive	Deceased	Age	If deceased, what was the cause of death?
Father	A	D	64	
Mother	A	D		

SMOKE CURRENTLY? (✓) NO ( ) YES ____PACKS PER DAY FOR ____ YEARS.

DRINK ALCOHOL? ( ) NO (✓) YES AMOUNT PER WEEK 2

HAVE YOU USED WITHIN THE LAST 30 DAYS; MARIJUANA, COCAINE, NARCOTICS OR ANY OTHER MIND-ALTERING SUBSTANCES?(I.E. STREET DRUGS) YES ( ) NO (✓)

IF YES, WHAT HAVE YOU USED?

HEIGHT: WEIGHT:

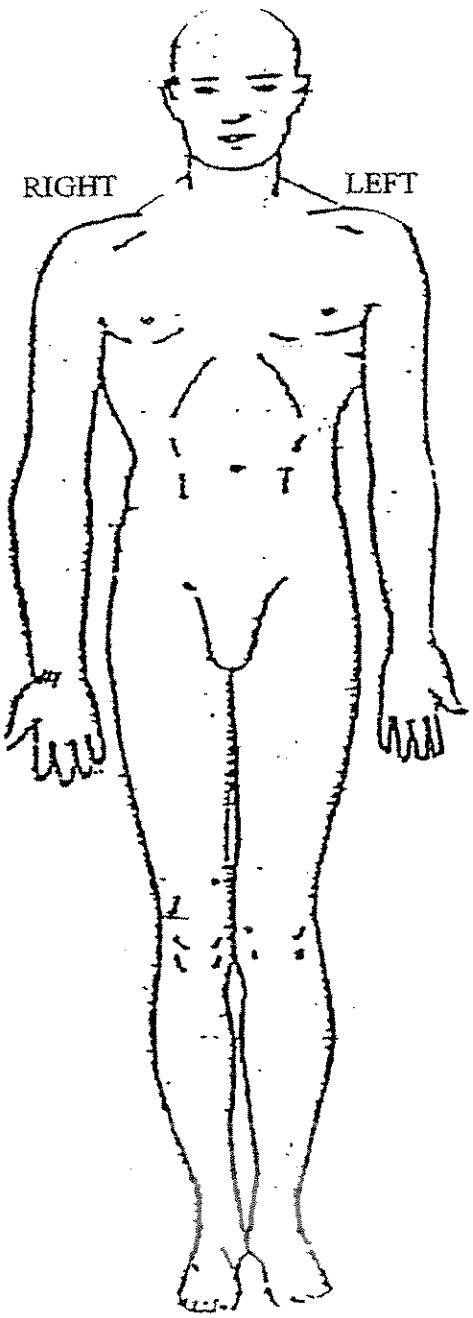
ORTHOPAEDIC CENTER Of South Florida

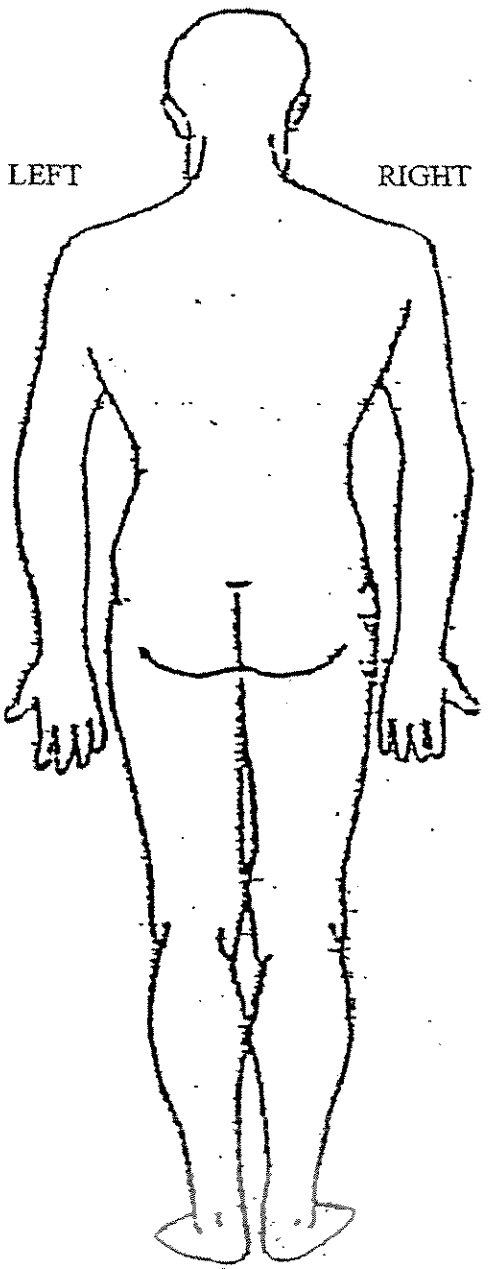
DATE 6/28/06

NAME Stephen Brew

Mark the areas on your body where you feel the described sensations. Use the appropriate symbols. Mark area of radiation. Include all affected areas.

NUMBNESS ==== PINS & NEEDLES OOOO BURNING XXXX STABBING ////
==== OOOO XXXX ////





MEDICAL SUMMARY

Patient: Stephen Norman Ostrov

Treating Physician: _____

I.
Diagnosis: burst Fx L-3

II.
Treatment: local Rx

III. Date of Last Treatment: 6/28/06

IV. Prognosis: fair

A. Will patient continue to have some pain for the foreseeable future? yes

Comments: _____

B. Has patient sustained any permanent physical impairment?

yes

If so, in what manner and to what extent will the patient be affected functionally?

some limitations in motion
pain (intermittent)
occasional spasm

C. Will this injury make the patient more susceptible to arthritic changes in the future?

yes

Comments:

degenerative disc disease

D. Do you anticipate future medical treatment of any nature as a result of this injury?

yes

Comments:

Possible C.T.
meds / injections

E. What is your estimate of the approximate range of costs of future treatment which may be necessary?

2,000 / year

F Was the automobile accident of **July 9, 2002** a *proximate* cause (more likely than not) of the injuries for which you treated this patient? And/or, in your opinion, is it more likely than not that the trauma from this accident activated and aggravated pre-existing medical conditions of this patient?

yes - caused burst fx + development of disc space arthritis

Doctor's Signature

Dated: 7/24/06

pi74b

INFOCOPY SYSTEMS, INC.

INVOICE NUMBER NOTE: INVOICE NUMBER MUST appear on all checks and correspondence regarding this invoice	Date Month/Day/Year
22282OCI	July 28, 06

Records From
Orthopaedic Center of South Florida
600 SOUTH PINE ISLAND RD Suite: 300
PLANTATION FL 33324

REMIT PAYMENT TO :
INFOCOPY
8095 NW 98 st
Miami, FL 33016
TAX No 65-0883895

BILLING INQUIRIES :
800-955-0244

Bill To
RICHARD S HUNTER
133 FAYETTEVILLE ST MALL Suite : 470
Raleigh NC 27602
Tel No.

Customer No : 20060727104933
Request No : 34764OCR
Request Date : July 27, 06
Patient Name : **OSTROV STEPHEN**
Medical Record : 261446
Date Delivered : July 28, 06
Policy/Ref. No :
Claim No :

Description	Quantity	Rate	Extended
Hard Paper Copy(ies)	4.00	1.00	4.00
Years Researched	1.00	1.00	1.00

Note:
To insure proper credit, please make check payable to Infocopy, Indicate the Invoice Number on your check and remit this invoice with your payment.

Subtotal	$	5.00
Sales Tax	$	0.33
Postage - S/H	$	0.55
Amount Due	$	5.88
Late Fee	$	0.00
Payment	$	0.00
Net Due	$	5.88

PAYMENT INFORMATION

☐ VISA ☐ ☐ ☐ DISCOVER ☐ *Check/Money Order*

Card Number _____ *Expiration Date(M/Y)* _____

Cardholder Name _____

Cardholder Address _____ *City* _____ *ST* _____ *Zip Code* _____

Terms and Conditions of Sale

1) Net Due Upon Receipt.
2) In the event payment is not received for this service, the requester / agent shall be liable for all costs of collection, including reasonable attorney fees, pre and post judgment.
3) In the event that payment is not made within the terms of this invoice, the buyer understands and agrees to pay a late fee charge of 1.5 % per month on the unpaid balance.

Infocopy Systems
"Release of Information Services"
8095 N.W. 98th Street
Miami, Florida 33016
(305) 822-0244 • Fax (305) 558-5760
EIN # 65-0883895

To: Requestor of Medical Records

From: The Hospital/Infocopy

Re: Medical Record Request

Per your request for the enclosed medical information, please be advised that **Infocopy** has been contracted as agent for the Hospital to make copies of Patient Medical Records. All requests from your office for patient information are forwarded to us and we make the copies on behalf of the Hospital.

The enclosed patient information is confidential and can only be used for the purpose authorized. Do not re-disclose, copy, or transmit this information to other parties without prior written consent of the Patient. To maintain patient's confidentiality, after use destroy all copies.

If there are any errors in the enclosed medical records copies, contact **Infocopy** customer service department immediately.

When applicable, we will ship copies to you and charge for postage and/or shipping and handling. Additionally, you will be responsible for document production charges as detailed in the enclosed invoice or per Florida Statute 395.3025 summarized below:

> *...Any licensed facility shall upon written request and with proper authorization provide a true and correct copy of all patient records, provided the person requesting such record pays the appropriate charges. The charge for **paper records** is up to $1.00 per page. The charge for **nonpaper records** (microfiche masters or CD images) is up to $2.00/page. The charge for searching is $1.00 per each year searched.*

Your written request for records and the acceptance of the enclosed copies represents an express agreement between you as requestor and/or agent and Infocopy, and you agree to pay copy charges plus, if applicable pre/post judgement, late fees of 1.5% per month, litigation fees associated with collecting overdue balances and venue for collection to be in Miami Dade County, Florida.

Invoice is enclosed (if applicable) and your prompt remittance is required to maintain credit. If you dispute charges and/or copies enclosed, you are restricted from using/copying the record and required to return the records and invoice "certified mail" with your written explanation of rejection within ten (10) days of receipt.

Please let us know if we can be of further assistance in regards to this matter.

Sincerely,

Infocopy Systems

CONTAINS
CONFIDENTIAL INFORMATION

261446
7/28/06

The Law Offices of
RICHARD S. HUNTER, JR.

Richard S. Hunter, Jr.*

Tammy J. Winstead,
Legal Assistant

*Certified Mediator

133 FAYETTEVILLE STREET MALL, SUITE 300
POST OFFICE DRAWER 470
RALEIGH, NORTH CAROLINA 27602-0470

Telephone: (919) 831-8722

Facsimile: (919) 831-8734
Email: hunterraty@aol.com

Website: www.rshunteraty.com

FACSIMILE COVER SHEET

Date: July 21, 2006
To: Tamera
Fax No.: 954-476-9077
From Tammy J. Winstead
Re: Stephen Norman Ostrov / Prognosis form for Dr. Rolnick
Transmitting: 10 pages (Including cover sheet)

Remarks: Please see attached. Thanks.

Please call if there are any difficulties receiving this transmission, or if you have any questions.

ATTENTION: The information contained in this facsimile message is attorney privileged and confidential information intended only for the use of the individual or entity named above and to be treated as such confidential information. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copy of this communication is strictly prohibited. If you have received this communication in error, please notify us by telephone and return the original message to us at the above address via US Mail.

INFOCOPY
(305) 822-0244
EMP _____ REQ. # 31704
DATE 7-27-06 # OG 4

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: Stephen Norman Ostrov Health Record Number

Date of Birth 9/22/59

1. I authorize the use or disclosure of the above named individual's health information as described below:
2. The following individual or organization is authorized to make the disclosure:

Address Dr. Rylnick
1600 S. Pine Island Rd., Ste. 300, Plantation, FL 33324

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

- ☐ problem list
- ☐ medication list
- ☐ list of allergies
- ☐ immunization record
- ☐ most recent history and physical
- ☐ most recent discharge summary
- ☐ laboratory results from (date) _____ to (date) _____
- ☐ x-ray and imaging reports from (date) _____ to (date) _____
- ☐ consultation reports from (doctors' names) _____
- ☐ entire record
- ☒ other

* Complete medical records
* billing stmts
* prognosis report (attached)

4. I understand that the information in my health record may include information relating to sexually transmitted dise immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information abo or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:
The Law Offices of Richard S. Hunter, Jr.
Address: PO Drawer 470 Raleigh, NC 27602-0470
for the purpose of personal injury

6. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I : in writing and present my written revocation to the health information management department. I understand the : will not apply to information that has already been released in response to this authorization. I understand the rev not apply to my insurance company when the law provides my insurer with the right to contest a claim under my p Unless otherwise revoked, this authorization will expire on the following date, event or condition: 6 mos to specify an expiration date, event or condition, this authorization will expire in six months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authori need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have que disclosure of my health information, I can contact (insert HIM director, privacy officer, or other office or individua contact information).

X _____ X 6/29/06
Signature of Patient or Legal Representative Date

_____ X _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

NOTE: The type of documents listed on the authorization form above may need to be modified depending on the particular health setting. Condition specific forms should be developed for research, or when a covered entity is information for which it will be remunerated, etc.